Chesterfield Health and Wellbeing Partnership Plan

2016 - 2018

INTRODUCTION

This locality plan sets out the priorities and actions for improving the health and wellbeing of people in Chesterfield. Good progress has been made in terms of developing partnership projects to address the wider determinants of health. However, activity needs to be sustained and advanced to further reduce health inequalities within the Borough.

The Chesterfield Health Profile 2015 can be viewed here: www.apho.org.uk/resource/view.aspx?RID=171698 and in Appendix 2.
The 2014 Health Profile shows that 14 out of the 32 indicators were significantly worse than the England average. In 2015 13 indicators are significantly worse than the England average.
The 2015 Chesterfield Geoprofile compares Chesterfield against Derbyshire and England averages and can be viewed here: http://observatory.derbyshire.gov.uk/IAS/Custom/Pages/profiles/healthprofiles/areaprofiles.aspx.
The profile for children shows that there are 5 indicators that are significantly worse than the Derbyshire average, and the profile for adults shows that there are 12 indicators that are significantly worse than the Derbyshire average.

- Chesterfield is the largest town in the County of Derbyshire with a population of just over 104,000, 94% of whom are White British and fewer than 6% are from other ethnic groups. The population of the Borough is set to rise to over 110,000 by 2035. Population projections show an ageing population, such that by 2035 28% of the population will be over 65.
- Chesterfield is a relatively compact area and is a major centre of employment (over 48,000 people work in the Borough) and attracts almost 20,000 inbound commuters a day.
- Whilst thought of as an urban area, just under half of Chesterfield Borough is open space and open countryside containing river/canal corridors, parks, farmland, hedgerows and woodland.
- Due to the diverse character of the Borough there are a great variety of issues facing communities. There is a distinct difference in deprivation levels between the East and West of the Borough:
    - Western suburbs of Holme Hall, Brockwell, Ashgate, Brampton, Brookside and Walton are largely residential areas built around the valleys of Holme Brook and the River Hipper. This part of the Borough, along with Linacre ward, has the highest levels of car ownership, the highest levels of people with higher qualifications and the lowest levels of deprivation.
    - Within the east of the Borough is the town of Staveley which has several areas of high deprivation and high unemployment. These are Middlecroft, Hollingwood and Inkersall and also the smaller communities of Poolsbrook, Duckmanton, Mastin Moor and Barrow Hill.

INDICES OF MULTIPLE DEPRIVATION 2015

There are 326 English local authority districts included in the Indices of Multiple Deprivation.

- In 2015 Chesterfield is the 85th most deprived district (91st in 2010)

England is divided into 32,844 Lower Layer Super Output Areas (LSOA's) ranked from 1 as the most deprived, to 32,844 as the least deprived.
There are various measures reported in seven domains.

- There are 68 LSOA's in Chesterfield
- 6 of Chesterfields LSOA's fall within the top 10% of most deprived areas in England across all domains (5 in 2010)
- A further 14 LSOA's fall within the top 20% of most deprived areas (12 in 2010)

Some actions identified in this plan will be borough-wide initiatives. Other actions will be targeted at the areas where identified need is greatest and therefore where the biggest difference can be made. Interventions will be focused in the following areas:

LSOAs (IMD top 10%)

- **Birdholme Central**
- **Loundsley Green East**
- **Poolsbrook**
- **Birdholme North**
- **Middlecroft Central**
- **Barrow Hill**

LSOAs (IMD top 20%)

- **Staveley Central**
- **Duckmanton**
- **Old Whittington East**
- **Dunston South East**
- **Brampton South**
- **Hasland North East**
- **Pevensey**
- **Boythorpe**
- **Stonegravels**
- **Mastin Moor**
- **Dunston North**
- **Stonegravels South**
- **Newbold Moor**
- **Middlecroft West**

https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

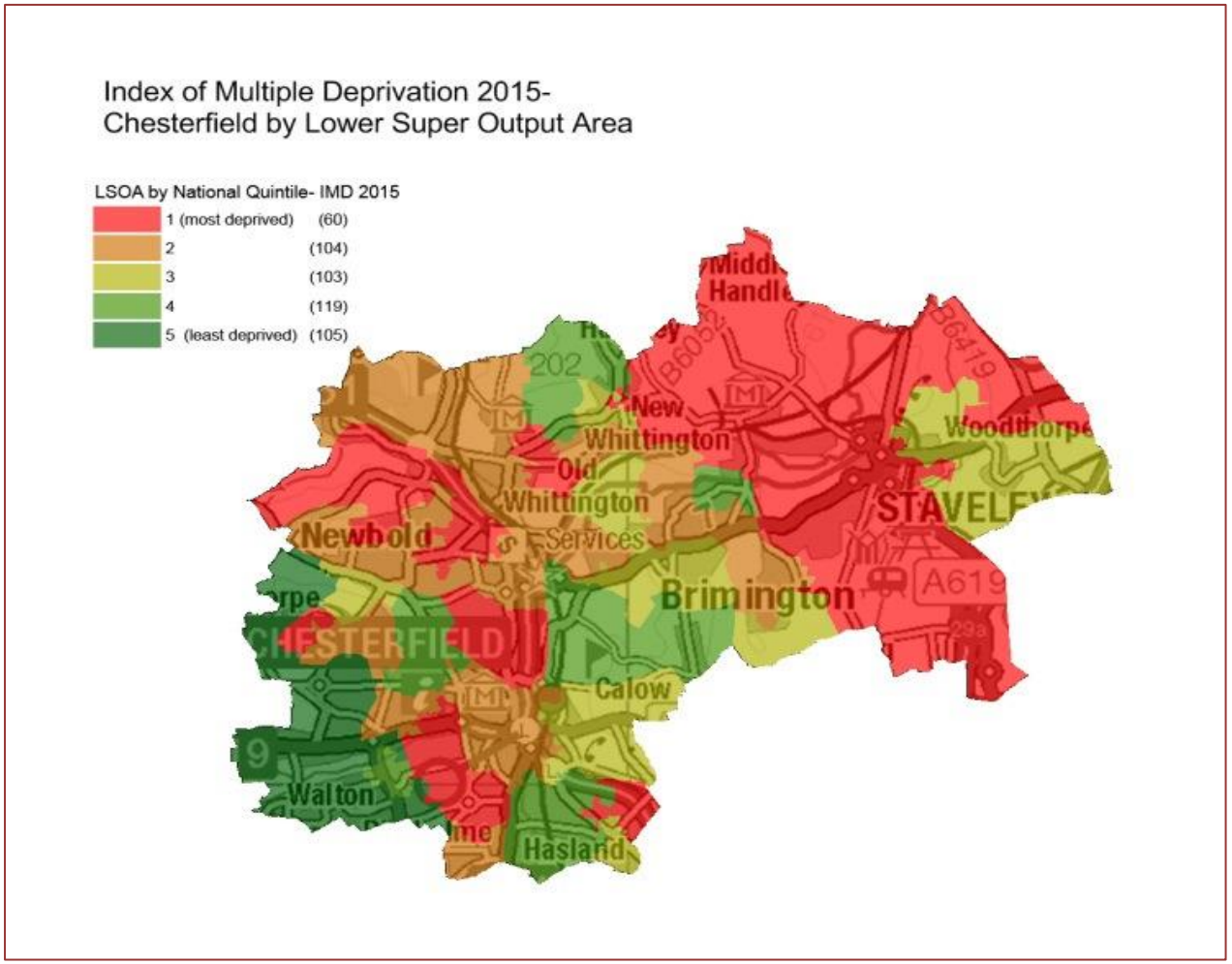

Figure 1: Percentage of LSOAs by IMD decile in Chesterfield (Red is most deprived)

PARTNERSHIP WORKING AND RESOURCES

Partnership working is critical to achieving improvements in health and wellbeing at a local level. Working together to identify priorities which are important to all partners and have relevance to their plans and strategies encourages ownership of the delivery plan.
The current economic climate does mean that resources are limited and will be for the foreseeable future. It is therefore imperative that effective multi-agency partnership working is prominent so that the impact of support and service provision can be maximised. This will help to ensure that duplication is reduced and resources are utilised to their full potential.

THE CHESTERFIELD HEALTH AND WELLBEING PARTNERSHIP

The Chesterfield Health and Wellbeing Partnership was established in 2015 with a purpose to contribute to improving health and wellbeing in Chesterfield.

Aims:

a) Produce, govern and monitor the Healthy Chesterfield Plan including the allocation of finances with support from the Local Area Committee
b) Provide oversight of the projects and programmes that contribute to reducing inequalities in health
c) Co-ordinate the engagement with communities and organisations within the Borough that contribute to health and wellbeing.

This locality partnership plan is designed to

- optimise and facilitate the local delivery of countywide and statutory services
- identify any deficits in support and service coverage
- respond to locally appropriate needs
- enable specific action at ward level or at lower super output area level
- enable a collaborative partnership approach

Derbyshire Health and Wellbeing Strategy: 2015- 2017			
"To reduce health inequalities and improve health and wellbeing across all stages of life by working in partnership with our communities."			
Keep people healthy and independent in their own home	**Build social capital**	**Create Healthy communities**	**Support the emotional health and wellbeing of children and young people**

Chesterfield Health and Wellbeing Partnership Priorities

Five priorities, which align with the Derbyshire Health and Wellbeing Board priorities and other local partner priorities, have been outlined:

1. Social Capital
2. Financial Inclusion
3. Mental Health and Wellbeing
4. Healthy Lifestyles
5. People

To support delivery, an operational locality action plan will accompany this plan.

Method in Target Areas

To deliver against the priorities, an innovative multi-agency partnership approach will be utilised in target areas.

This approach began in the Rother ward.

Some key principles form the approach

1. Identifying Need (IMD, Indicators, Customer Segmentation)	
2. Asset Mapping	What resource is there?
3. Community Engagement	Create relationships
4. Community Consultation	What do people want?
5. Local Action Plan	Develop and deliver actions
6. Ongoing Engagement, Consultation and Delivery	Sustain relationships, utilise method as default process

This approach is based on social capital principles and empowerment of communities, matching support to need.

Target areas are outlined in Appendix 3.

Chesterfield Healthy Communities Priority

Chesterfield Borough Council has been accepted as an affiliate member of the World Health Organisation (WHO) Healthy Cities Network. A key priority has been agreed. This locality health and wellbeing plan will lead development and delivery of the priority.

"Over the next two years, by working with our communities and partners, we will enable increased physical activity for our younger people, promote healthy eating and support communities to design sustainable solutions"

Headline Action Plan

- Strategic opportunities for parks and green space
- Community development
- Physical Activity Offer
    - New Queens Park Sport Centre and Staveley Healthy Living Centre
    - Outreach
    - Inactivity
    - Schools
- Healthy Eating
    - Promote and Further Embed Heart of Derbyshire
    - Eat Well, Waste Less
    - Schools
    - Community
    - Environment

Chesterfield Health and Wellbeing Partnership Plan Priorities

Priority 1: Social Capital

'Social Capital is about the relationships, networks and trust which help people to support each other, build confidence, and create the opportunities to bring about change in their lives and communities'

Derbyshire Health and Wellbeing Board Priority: Social Capital underpins the approach to Healthy Communities

Chesterfield Indicators – Worse than the England average

- Lower life expectancy for males and females
- Gap in life expectancy at birth between each local authority and England
- Pupils attaining 5 GCSE grades (A* to C)

What do we want to achieve?

- Identify and utilise community settings to develop trusted points of contact for engagement, consultation and support
- Empowering individuals and communities to have involvement in decisions that affect them and to be involved in co-design and co-production of support and services
- Communities are enabled to support themselves and become more resilient, reducing the need to access services
- Use of a strengths-based inclusive approach to working with communities to help identify, recognise and utilise assets, rather than focusing on deficits or restricting use
- Individuals and communities are encouraged to seek early help, promote self-care and prevent ill health
- Development of a targeted programme of support to those communities in greatest need
- Raise aspiration, education, skills, competencies and opportunity
- Identify examples of best practice, share and grow

Strategic Actions 2016-18

- Enable strong community resilience
- Complete detailed analysis, asset mapping, community engagement and consultation in identified wards, with a view to developing a specified action plan and sustainable structure of engagement
- Identify, develop and support a core infrastructure of the voluntary sector
- Implement the agreed findings of the volunteering sub-group

Priority 2: Financial Inclusion

'People are said to be living in poverty if their income and resources are so inadequate as to preclude them from having a standard of living considered acceptable in the society in which they live. Because of their poverty they may experience multiple disadvantage through unemployment, low income, poor housing, inadequate health care and barriers to lifelong learning, culture, sport and recreation'

Chesterfield Indicators – Worse than the England average

- Deprivation - Chesterfield is the 85th most deprived local authority out of 326 local authorities in England (2015)
- Children under 16 living in poverty
- Long term unemployed

What do we want to achieve?

- People have more choice and control over their lives
- People and communities are more resilient and better able to deal with the stresses in everyday life and at times of crisis
- Improve financial resilience within communities by helping them to become more financially aware, to maximise their income, promoting a saving culture and providing access to good quality advice
- Improve life skills in younger people
- Maximise the opportunities and progression for people to achieve financial stability

Strategic Actions 2016-18

- Support delivery of the countywide financial inclusion agenda, adding local value
- Improve links between local partners to raise awareness and maximise the use of existing resource and support
- Maximise opportunities for training and jobs, including future-planning related to economic generation and the job market

Priority 3: Mental Health and Wellbeing

Mental health and wellbeing is an important part of overall health and wellbeing and can be affected by different factors, including life events such as relationship breakdown, bereavement, financial difficulty and work stress. Mental health conditions range from feeling down, to depression/anxiety, to psychoses. A state of wellbeing can be defined as 'in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community'.

Chesterfield Indicators – Worse than the England average

- Suicide
- Hospital stays for self-harm
- Hospital admissions caused by unintentional / deliberate injuries in young people

What do we want to achieve?

- To build resilience and promote positive wellbeing for residents of Chesterfield of all ages
- To increase access to, and availability of, low level support and early intervention services for people at risk of mental ill health problems
- Ensure that more people with mental ill health problems recover and have a good quality of life, including a greater ability to manage their own lives, stronger social relationships and a greater sense of purpose
- Inequalities, stigma and discrimination suffered by people experiencing mental ill health problems and mental illness are reduced

Strategic Actions 2016-18

- Establish a collaborative Chesterfield Mental Health Network
- Maximise joint working and appropriate support, especially for high level service receivers
- Develop local implementation of suicide prevention and self-harm prevention
- Develop a workforce that is informed, proactive and responsive to mental health and wellbeing issues
- Decrease stigma of mental ill health
- Promote positive mental wellbeing

Priority 4: Healthy Lifestyles

Promoting good health and healthy behaviours at all ages to prevent or delay the development of chronic disease. Being physically active, eating a healthy diet, avoiding the harmful use of alcohol and not smoking can all reduce the risk of chronic disease in middle and older age. These behaviours should start in early life and continue into older age.

Chesterfield Indicators – worse than the England average

- Life expectancy at birth
- Mortality from causes considered preventable
- U75 mortality cardiovascular disease
- Higher levels of premature death from cardiovascular diseases
- U75 mortality Cancer
- Hospital stays for alcohol related harm
- Drug misuse
- Higher prevalence of opiate and/or crack use
- Obese adults
- Excess weight in adults
- Recorded diabetes
- Inactive adults
- Smoking at time of delivery
- Smoking related deaths
- Breastfeeding

What do we want to achieve?

- Work together to make sure all communities, services and places where local people live, work, learn and socialise consistently offer every opportunity to support healthier lifestyles and promote wellbeing
- Supporting people to improve their quality and quantity of life
- Raising awareness of conditions, risk factors and protective factors
- Support for local people to take control and lead the promotion of healthy lifestyles within their families and communities
- Innovative methods are used to promote health messages and offer solutions to create healthy communities

Strategic Actions 2016-18

- Working towards delivery of the Healthy Communities priority
- Support local implementation of healthy lifestyle programmes
- Develop and support healthy environments

- Develop and maximise points of contact for health and wellbeing promotion

Priority 5: People

To ensure an understanding of the needs and aspirations of people in the local community, by utilising the community led approach to health improvement. Supporting hard-to-reach people to identify what is important to them about their health and wellbeing, identify the factors that impact on their wellbeing and help them in co-producing and implementing solutions. One of the main challenges today is that people are living longer; however morbidity is increasing, with more people spending more time in poorer health with long term conditions. One of the main focuses within this priority is to ensure that our ageing population live in the best possible health and receive the support they require to live full, independent lives at home.

Chesterfield Indicators worse than the England average

- Deaths from all causes, all ages
- Healthy life expectancy for males and females
- Disability free life expectancy for males and females
- General health very bad (%)
- Emergency hospital admissions for all causes
- Health related quality of life for older people
- Older people in deprivation
- Injuries due to falls in persons aged 65+, 2,527 incidents (England average 2,206)
- Pensioners living alone
- Provision of 50 hours + of unpaid care per week (%)

What do we want to achieve?

- People maintain independence and a good quality of life
- Strengthen the opportunities for older people to participate in activities to remain fully involved in work, leisure activity, housing, learning and community life
- More innovative and accessible opportunities to prevent social isolation
- Older people know where to go for support, receive support early to prevent and avoid the need for acute care
- Specific support for frail elderly and those experiencing a significant event

Strategic Actions 2016-18

- Chesterfield to be a safe and friendly place (Dementia Friendly, Safe Place etc.)
- Enable engagement, assessment and access to appropriate multi-agency support
- Promote and maximise opportunities for social interaction, learning and physical activity

Appendix 1: Public Health programmes or initiatives covering all localities in Derbyshire in 2016-17

STARTING AND DEVELOPING WELL

- (Health Visiting*)
- Breastfeeding support
- National Child Measurement Programme
- HENRY (Health Exercise and Nutrition for the Really Young)
- School breakfast clubs
- Five60 (Healthy eating, physical activity and obesity prevention)
- Citizens advice in Children's Centres
- Young people's sexual health service
- Young people's drug and alcohol services

LIVING AND WORKING WELL

- Wellbeing Service
- Tobacco Control, including illicit and illegal tobacco
- Smoking cessation
- Weight management
- Physical Inactivity
- Health Referral Scheme
- Walking for Health groups
- Make Every Contact Count (MECC)
- Sexual health services
- Drug and alcohol services – tier 2 and 3
- Family and carer support for drug users
- Heart of Derbyshire
- Derbyshire Healthy Workplaces

HEALTH INEQUALITIES

- Citizens advice in GP surgeries
- Credit Union development
- Affordable warmth programme
- Food bank support
- Support for welfare assessment

AGEING WELL

- Health Checks (40+)
- Falls prevention programme
- Social isolation initiative
- Foot care programme

Appendix 2:

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Health summary for Chesterfield

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average

Regional average* | England Average | England Worst | 25th Percentile | 75th Percentile | England Best | England Range

Domain	Indicator	Local No Per Year	Local value	Eng value	Eng worst	Eng best
Our communities	1 Deprivation	36,985	25.5	26.4	83.8	0.0
	2 Children in poverty (under 16s)	3,745	21.0	18.2	37.9	5.8
	3 Statutory homelessness	108	2.1	2.3	12.5	0.0
	4 GCSE achieved (5A*-C inc. Eng & Maths)†	698	53.6	56.8	35.4	78.9
	5 Violent crime (violence offences)	1,098	18.5	11.1	37.8	2.8
	6 Long term unemployment	518	7.9	7.1	33.5	0.9
Children's and young people's health	7 Smoking status at time of delivery	171	14.7	12.0	37.5	1.9
	8 Breastfeeding initiation	808	75.3	73.9		
	9 Obese children (Year 6)	171	18.2	19.1	27.1	9.4
	10 Alcohol-specific hospital stays (under 18)†	11.7	53.3	45.1	155.8	11.3
	11 Under 18 conceptions	45	34.3	34.3	44.0	7.6
Adults' health and lifestyle	12 Smoking prevalence	n/a	20.3	18.4	30.0	9.5
	13 Percentage of physically active adults	257	53.6	56.0	43.5	66.7
	14 Obese adults	n/a	26.5	23.0	35.2	11.3
	15 Excess weight in adults	176	67.7	63.8	75.9	45.9
Disease and poor health	16 Incidence of malignant melanoma†	15.8	16.2	18.4	36.0	4.8
	17 Hospital stays for self-harm	465	448.7	203.2	682.7	68.9
	18 Hospital stays for alcohol related harm†	949	901	645	1231	366
	19 Prevalence of opiate and/or crack use	896	13.3	8.4	35.0	1.4
	20 Recorded diabetes	6,951	7.4	6.2	9.0	5.4
	21 Incidence of TB†	6.7	6.4	14.8	113.7	0.0
	22 New STI (exc Chlamydia aged under 25)	474	707	832	3269	172
	23 Hip fractures in people aged 65 and over	145	646	580	839	354
Life expectancy and causes of death	24 Excess winter deaths (three year)	44.7	13.4	17.4	34.3	3.9
	25 Life expectancy at birth (Male)	n/a	78.2	78.4	74.3	83.5
	26 Life expectancy at birth (Female)	n/a	82.2	82.1	80.0	86.4
	27 Infant mortality	3	3.8	4.0	7.6	1.1
	28 Smoking related deaths	198	315.0	288.7	471.6	167.4
	29 Suicide rate	5	-	8.8		
	30 Under 75 mortality rate: cardiovascular	93	97.8	78.2	137.0	37.1
	31 Under 75 mortality rate: cancer	143	153.5	144.4	202.9	104.8
	32 Killed and seriously injured on roads	29	27.9	38.7	119.6	7.8

Indicator notes

1 % people in this area living in 20% most deprived areas in England, 2013 2 % children (under 16) in families receiving means-tested benefits & low income, 2012 3 Crude rate per 1,000 households, 2013/14 4 % key stage 4, 2013/14 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2013/14 6 Crude rate per 1,000 population aged 16-64, 2014 7 % of women who smoke at time of delivery, 2013/14 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery, 2013/14 9 % school children in Year 6 (age 10-11), 2013/14 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2011/12 to 2013/14 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2013 12 % adults aged 18 and over who smoke, 2013 13 % adults achieving at least 150 mins physical activity per week, 2013 14 % adults classified as obese, Active People Survey 2012 15 % adults classified as overweight or obese, Active People Survey 2012 16 Directly age-standardised rate per 100,000 population, aged under 75, 2010-12 17 Directly age sex standardised rate per 100,000 population, 2013/14 18 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, directly age standardised rate per 100,000 population, 2013/14 19 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2011/12 20 % people on GP registers with a recorded diagnosis of diabetes 2013/14 21 Crude rate per 100,000 population, 2011-13, local number per year figure is the average count 22 All new STI diagnoses (excluding Chlamydia under age 25), crude rate per 100,000 population, 2013 23 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over, 2013/14 24 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 01.08.10-31.07.13 25, 26 At birth, 2011-13 27 Rate per 1,000 live births, 2011-13 28 Directly age standardised rate per 100,000 population aged 35 and over, 2011-13 29 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, 2011-13 30 Directly age standardised rate per 100,000 population aged under 75, 2011-13 31 Directly age standardised rate per 100,000 population aged under 75, 2011-13 32 Rate per 100,000 population, 2011-13

† Indicator has had methodological changes so is not directly comparable with previously released values. * "Regional" refers to the former government regions.

More information is available at www.healthprofiles.info and http://fingertips.phe.org.uk/profile/health-profiles Please send any enquiries to healthprofiles@phe.gov.uk

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Appendix 3: Chesterfield Health and Wellbeing Partnership Target Wards 2016-18

In conjunction with work being performed as part of the Inactivity Project, the first 4 stages of the approach will be initially conducted and supported by a consultancy firm, Press Red.

To maximise the impact where people can benefit most the Indices of Multiple Deprivation (IMD) 2015 provides compelling evidence of where to focus resource.

LSOAs (IMD top 10%)

LSOA	Ward
Birdholme Central	Rother
Poolsbrook	Middlecroft & Poolsbrook
Middlecroft Central	Middlecroft & Poolsbrook
Birdholme North	Rother
Barrow Hill	Barrow Hill & New Whittington
Loundsley Green East	Loundsley Green

LSOAs (IMD top 20%)

LSOA	Ward
Staveley Central	Lowgates & Woodthorpe
Duckmanton	Hollingwood & Inkersall
Old Whittington East	Old Whittington
Dunston South East	Dunston
Brampton South	Holmebrook
Hasland North East	Hasland
Pevensey	St Helens
Boythorpe	Rother
Stonegravels	St Helens
Mastin Moor	Lowgates & Woodthorpe
Dunston North	Dunston
Stonegravels South	St Helens
Newbold Moor	Moor
Middlecroft West	Middlecroft & Poolsbrook

Target Areas

Ideally we'd be able to employ this approach in each ward across the Borough, but the intensity and resource required allows only for a staged approach, with an initial plan featuring 7 wards.

	Ward	Timescale for start
1	**Rother**	June 2015
2	**Barrow Hill and New Whittington (Barrow Hill)**	May 2016
3	**Loundsley Green**	August 2016
4	**St Helens**	December 2016
5	**Middlecroft and Poolsbrook**	April 2017
6	**Lowgates and Woodthorpe**	August 2017
7	**Hasland (Hasland North East)**	December 2017